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(54) **DIGITAL FIXATION METHOD OF  
IMPLANTING A SUPPORT IN A PATIENT**

(71) Applicant: **Coloplast A/S**, Humlebaek (DK)

(72) Inventors: **Scott Schneider**, Charlotte, NC (US);  
**Sarah J. Deitch**, Minneapolis, MN  
(US); **Emily C. Daley**, Brooklyn  
Center, MN (US)

(73) Assignee: **Coloplast A/S**, Humlebaek (DK)

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division of application No. 12/912,788, filed on Oct.  
27, 2010, now Pat. No. 8,257,366.

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**A61B 17/00** (2006.01)

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(2013.01); **A61B 2017/0464** (2013.01)

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2017/00265; A61B 2017/00138; A61B 19/04  
See application file for complete search history.

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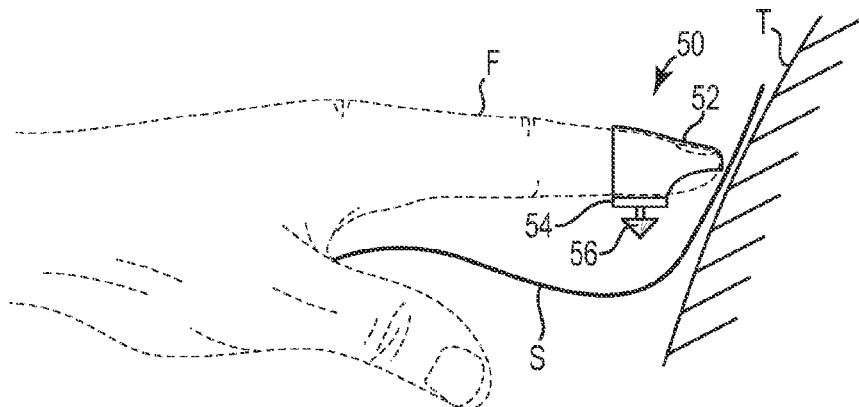
*Primary Examiner* — Melanie Tyson

(74) *Attorney, Agent, or Firm* — Coloplast Corp., Coloplast  
A/S; Nick Baumann

(57) **ABSTRACT**

A method of implanting a support in a patient includes  
providing an anchor introducer that is wearable on a finger,  
and wearing the anchor introducer on the finger and posi-  
tioning the anchor introducer such that at least a distal tip of  
the finger is available for palpating tissue internal to the  
patient. The method also includes attaching an anchor to the  
anchor introducer, and inserting the finger that is wearing the  
anchor introducer into an incision and palpating a tissue  
landmark inside a pelvis of the patient with the distal tip of  
the finger. The method additionally includes driving the  
anchor into the tissue landmark inside the pelvis of the  
patient, detaching the anchor from the anchor introducer,  
associating the support with the anchor, and securing the  
support to the tissue landmark inside the pelvis of the  
patient.

**8 Claims, 6 Drawing Sheets**



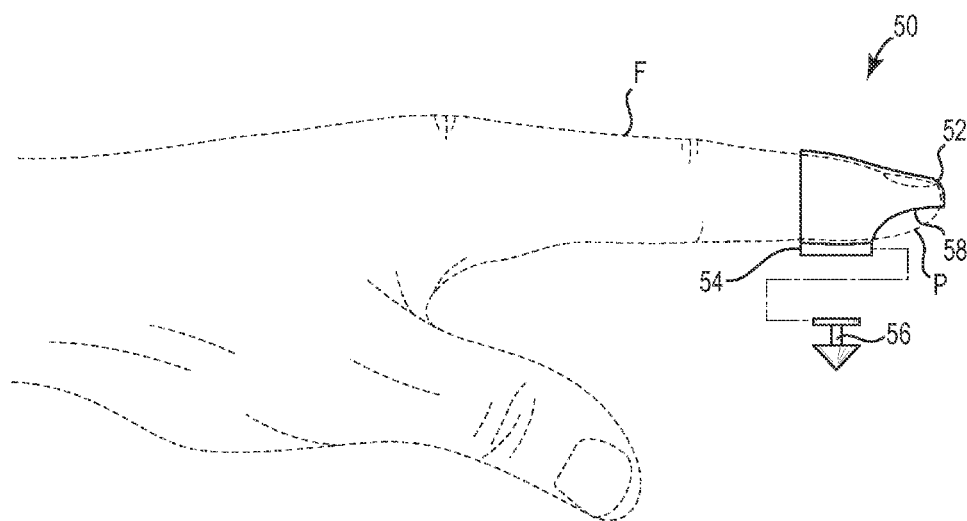
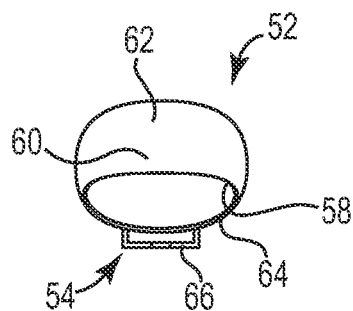
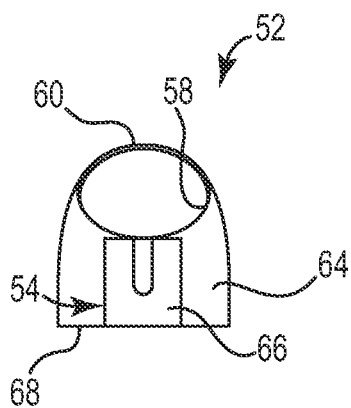


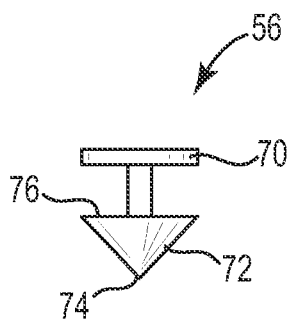
Fig. 1



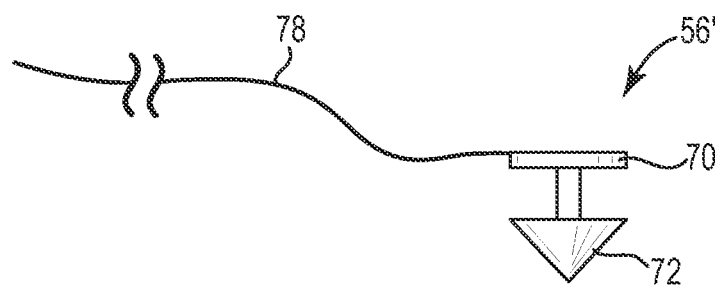
**Fig. 2**



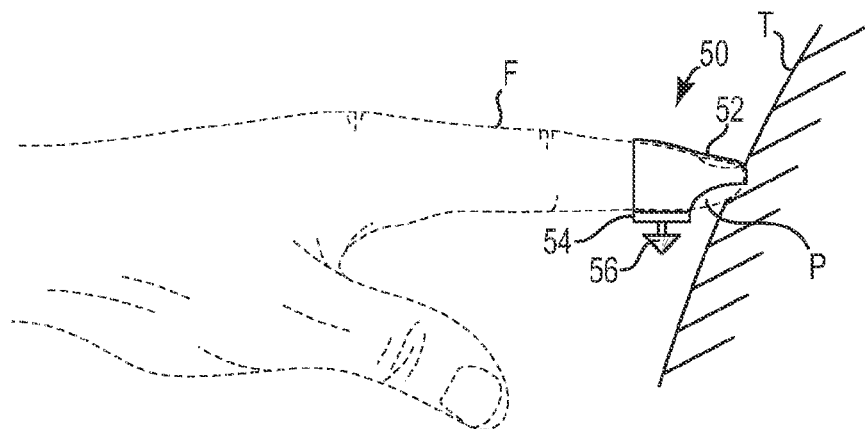
**Fig. 3**



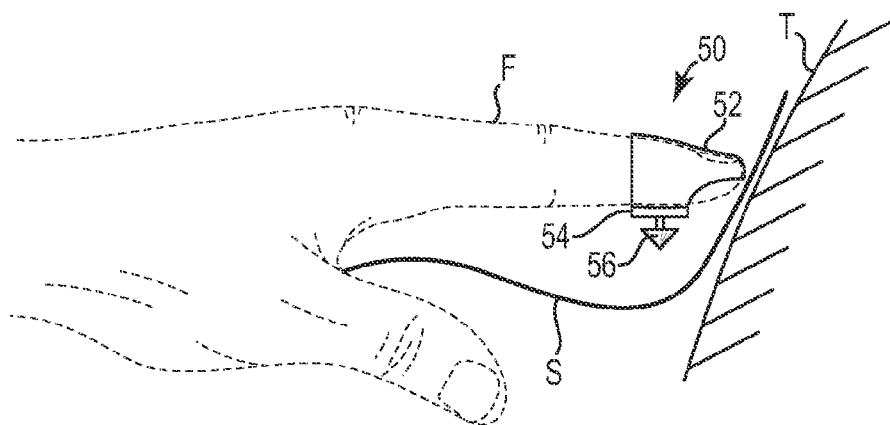
**Fig. 4**



**Fig. 5**



**Fig. 6A**



**Fig. 6B**

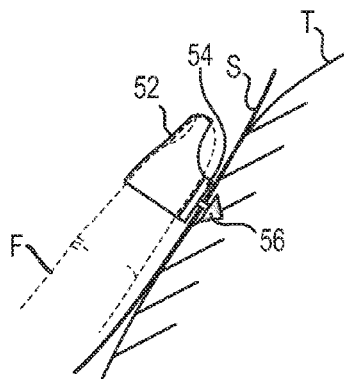


Fig. 6C

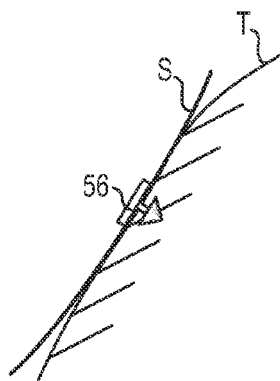


Fig. 6D

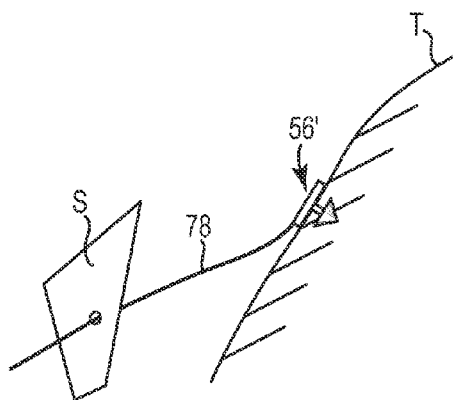


Fig. 6E

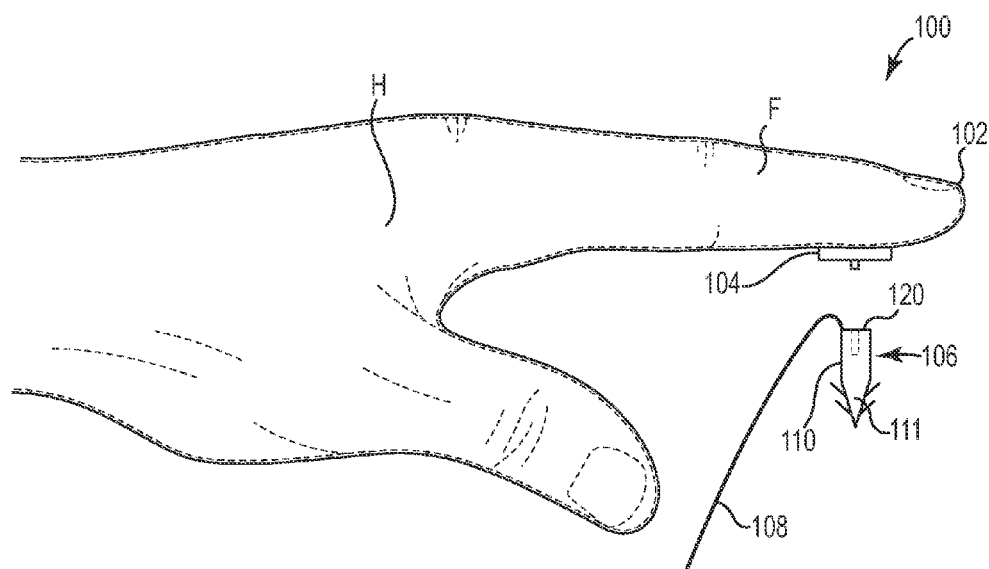


Fig. 7

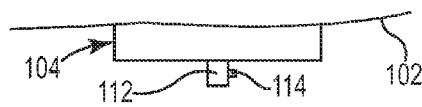


Fig. 8A

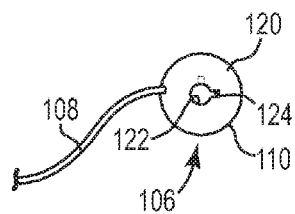


Fig. 8B

1

## DIGITAL FIXATION METHOD OF IMPLANTING A SUPPORT IN A PATIENT

### BACKGROUND

Intracorporeal suturing of tissue during surgery presents challenges to the surgeon in that the surgeon is called upon to manipulate one or more suturing instruments within the confines of an incision formed in the patient's body. In some cases, the surgeon will use his/her finger(s) to dissect tissue or separate tissue along tissue planes to form a space within the tissue that allows the surgeon to palpate and identify a desired target location for placement of a suture. Often, the space formed in the dissected tissue is opened until it is large enough to receive both the surgeon's finger(s) and the suturing instrument(s). The space provides access to the identified target location where it is desired to place the suture. However, the intracorporeal target location is often disposed at an angle that is difficult to reach and can have a depth that precludes visualization of the target location. Delivering surgical instruments to the target location is challenging when the target location cannot be visualized by the surgeon.

### SUMMARY

One aspect provides a method of fixing a suture to tissue of a patient. The method includes placing an introducer onto a finger; attaching an anchor to the introducer; delivering the introducer into the patient's body with the finger; and driving the anchor with the finger into the tissue of the patient.

### BRIEF DESCRIPTION OF THE DRAWINGS

The accompanying drawings are included to provide a further understanding of embodiments and are incorporated in and constitute a part of this specification. The drawings illustrate embodiments and together with the description serve to explain principles of embodiments. Other embodiments and many of the intended advantages of embodiments will be readily appreciated as they become better understood by reference to the following detailed description. The elements of the drawings are not necessarily to scale relative to each other. Like reference numerals designate corresponding similar parts.

FIG. 1 is a side view of a digital suture fixation system including an introducer and an anchor delivery device according to one embodiment.

FIG. 2 is a front view of the introducer illustrated in FIG. 1.

FIG. 3 is a bottom view of the introducer illustrated in FIG. 2.

FIG. 4 is a side view of an anchor as illustrated in FIG. 1.

FIG. 5 is a side view of one embodiment of a suture assembly suited for use with the digital suture fixation system illustrated in FIG. 1.

FIG. 6A is a perspective view of a finger wearing the introducer illustrated in FIG. 1 and palpating tissue of a patient.

FIG. 6B is a perspective view illustrating the placement of support material between the finger and the tissue of the patient.

FIG. 6C is a perspective view of the finger illustrated in FIG. 6A inserting an anchor through the support material and into the tissue of the patient.

2

FIG. 6D is a side view of the anchor illustrated in FIG. 6C fixing support material to the tissue of the patient.

FIG. 6E is a perspective view of one embodiment of support material delivered along a suture line to an anchor that has been placed into tissue.

FIG. 7 is a side view of a hand placed inside of a glove that includes a delivery device configured to deliver an anchor intracorporeally into a patient according to one embodiment.

FIG. 8A is a side view of the delivery device and FIG. 8B is a top view of the anchor as illustrated in FIG. 7.

### DETAILED DESCRIPTION

In the following Detailed Description, reference is made to the accompanying drawings, which form a part hereof, and in which is shown by way of illustration specific embodiments in which the invention may be practiced. In this regard, directional terminology, such as "top," "bottom," "front," "back," "leading," "trailing," etc., is used with reference to the orientation of the Figure(s) being described. Because components of embodiments can be positioned in a number of different orientations, the directional terminology is used for purposes of illustration and is in no way limiting. It is to be understood that other embodiments may be utilized and structural or logical changes may be made without departing from the scope of the present invention. The following detailed description, therefore, is not to be taken in a limiting sense, and the scope of the present invention is defined by the appended claims.

It is to be understood that the features of the various exemplary embodiments described herein may be combined with each other, unless specifically noted otherwise.

Tissue includes soft tissue, which includes dermal tissue, sub-dermal tissue, ligaments, tendons, or membranes. As employed in this specification, the term "tissue" does not include bone.

A finger cot covers, at most, one finger. One such finger cot is a thimble that covers only a portion of the finger, for example a distal portion of the finger. Another example of a finger cot is a flexible sleeve that covers a distal portion of the finger. In contrast, a glove covers all five fingers and a portion of the hand up to at least the wrist.

One embodiment provides a digital suture fixation system having an introducer that is attachable to a finger of a person and a delivery device attached to the introducer. The introducer is configured to allow the finger to palpate and identify a landmark within a patient and the delivery device is configured to insert an anchor or a suture attached to an anchor into the landmark. Thus, the surgeon's finger delivers the anchor/suture such that the space formed in the dissected tissue to locate the landmark need not be so large as to accommodate a separate suturing instrument.

In this specification "configured to allow the finger to palpate and identify a landmark" means that the finger has a level of sensitivity that allows the person to discriminate tissue boundaries and/or tissue layers. For example, often-times the person is palpating a location inside a patient that is not within view and embodiments of the digital suture fixation system provide an introducer that attaches to the person's finger while allowing the finger to sense and identify the tissue the person is touching. That is to say, the introducer does not diminish the sensitivity of at least the pad of the palpating finger. In one embodiment, the introducer includes a polymer thin-walled section having a wall thickness of less than about 0.005 inches that is suited for providing digital dexterity. In one embodiment, the intro-



3

ducer includes a window that allows the finger to directly contact the tissues that are palpated.

Embodiments provide a digital suture fixation system that is configured to be donned over a finger of a surgeon to allow the finger to palpate and identify a landmark within the patient, where the system includes a delivery device configured to insert an anchor at the identified landmark. Other embodiments provide a digital suture fixation system having a thimble-like device that is configured to be affixed to a finger of a surgeon and yet allow the finger to palpate and identify a landmark within the patient.

Embodiments provide a digital suture fixation system that allows the surgeon to use the same finger(s) that were used to dissect tissue and identify the target location to also place the anchor/suture. Since the finger both palpates the tissue and places the anchor/suture, the space formed in the dissected tissue need not be opened to be large enough to receive other suturing instrument(s). Since the finger has already been employed to identify the target landmark, the subsequent location of the target landmark is relatively easy, even if the intracorporeal target location is disposed at an angle that is difficult to reach with instruments.

FIG. 1 is a side view of a digital suture fixation system 50 attached to a finger F according to one embodiment. System 50 includes an introducer 52 that is attachable to the finger F, a delivery device 54 that is attached to introducer 52, and an anchor 56 that is removably attachable to deliver device 54.

The intracorporeal suturing of tissue often includes the surgeon using one or more fingers to dissect tissue from tissue planes. In one embodiment, introducer 52 is provided with a window 58 that is formed on a distal end portion to allow a finger pad P of the finger F to be exposed (uncovered) to palpate tissue of the patient and identify a landmark for the placement of anchor 56. Surgeons rely upon their well developed dexterity to palpate and identify landmarks of a patient, and this is particularly the case when the surgeon is unable to visually view the landmark site. One embodiment of system 50 provides a window 58 that is sized to expose the pad P of the finger to allow the pad P to directly contact the tissue of the patient.

As an example of the use of system 50, in one embodiment the surgeon forms an incision in the patient, for example to access to pelvic floor. Thereafter, the surgeon places introducer 52 over the finger F and enters the incision to dissect tissue to locate a desired landmark within the patient. Having located the landmark within the patient, the surgeon removes the finger F from the patient and attaches anchor 56 to the delivery device 54. Subsequently, the surgeon will retrace the intracorporeal pathway into the patient with the finger F having the introducer 52 in the anchor 56 attached to the delivery device 54 for placement of anchor 56 into the landmark. As described below, one or more anchors 56 are employed to repair or support the pelvic floor with the appropriate use of support material or suture line as determined by the surgeon during the surgery. In one embodiment, anchor 56 is pre-attached to the delivery device 54.

It is to be understood that the finger F of the surgeon could be enclosed within a glove, and the introducer 52 is suited for donning over the glove that encloses the finger F.

FIG. 2 is a front view of introducer 52. In one embodiment, introducer 52 includes a distal end 60 formed by the intersection of a top surface 62 and a bottom surface 64. In one embodiment, window 58 is formed at the distal end 60 between the top surface 62 and the bottom surface 64 of the introducer 52. As illustrated in FIG. 1 and FIG. 2, in one

4

embodiment introducer 52 is provided as a finger cot that is configured to snugly fit over the finger F of the surgeon (or the finger F of the surgeon that is enclosed within a glove).

Delivery device 54 is attached to the bottom surface 64 of introducer 52. In one embodiment, delivery device 54 is provided as a U-shaped dock having a shelf 66 that is spaced a distance away from the bottom surface 64. The anchor 56 (FIG. 1) is configured to slide into the delivery device 54 and be frictionally captured between the shelf 66 and the bottom surface 64 of the introducer 52.

The introducer 52 is suitably fabricated from polymers that are configured to elastically constrict over a finger of the surgeon. Some of the suitable polymers for fabricating the introducer 52 include polybutylene, polynitrile, polyurethane including polyurethane from the family of elastic polymers sold under the tradename KRATON, silicone, or block copolymers. In one embodiment, introducer 52 is formed from a malleable metal core, for example aluminum, that is over molded with silicone.

FIG. 3 is a bottom view of introducer 52 illustrating the U-shaped shelf 66. In one embodiment, shelf 66 extends from a proximal end 68 of introducer 52 up to the window 58. In this manner, delivery device 54 is located proximal of window 58 and does not impede with the window 58 or interfere with the dexterity of the finger pad P (FIG. 1).

Delivery device 54 is suitably fabricated from plastic materials such as polypropylene, polyethylene, silicone, or blends of polyolefin plastics. Delivery device 54 is attached to introducer 52, for example by adhesives, ultrasonic welds, or molding. In one embodiment, introducer 52 and delivery device 54 are formed (molded) as a single integral unit.

FIG. 4 is a side view of anchor 56. In one embodiment, anchor 56 is provided as a tissue penetrating anchor including a flange 70 and a tissue penetrating barb 72 extending from flange 70. Flange 70 provides an attachment mechanism to removably secure anchor 56 to delivery device 54 (FIG. 2). The tissue penetrating barb 72 includes a leading end 74 configured to penetrate tissue and a trailing end 76 configured to secure barb 72 in the tissue and resist removal of barb 72 from the tissue after placement of anchor 56.

FIG. 5 is a side view of another embodiment of an anchor 56' including a suture line 78 attached to flange 70. In one embodiment, suture line 78 is connected to anchor 56' and provides a pulley line along which support material or other material may be directed along line 78 to the tissue into which anchor 56' is fixed. In one embodiment, anchors 56, 56' are molded from polypropylene. In one embodiment, anchors 56, 56' are molded from a polymer having a melting point similar to a melting point of suture line 78, which enables suture line 78 to be thermally "welded" to anchors 56, 56'. Suitable suture line materials include suture employed by surgeons in effecting pelvic floor repair, such as polypropylene suture, or the suture identified as Deklene, Deknatel brand suture, as available from Teleflex Medical, Mansfield, Mass., or suture available from Ethicon, a Johnson&Johnson Company, located in Somerville, N.J.

FIGS. 6A-6E illustrate embodiments of system 50 employed in a one-handed method of fixing a suture to tissue of a patient, or more particularly, a method of driving an anchor into tissue of the patient with the same finger that was employed to palpate/identify the target landmark.

FIG. 6A is a perspective view of digital suture fixation system 50 placed on the finger F. The pad P of the finger F is exposed in the window 58 of introducer 52 and is available to palpate tissue T of the patient. In one approach, the surgeon will place the introducer 52 onto the finger F, load the anchor 56 into the delivery device 54, and follow a

5

pathway into the tissue that has been previously dissected by the finger F. In this manner, the surgeon is able to identify the desired landmark on the tissue T just prior to deploying the anchor **56**.

FIG. 6B is a side view of a hand of the surgeon holding support material S at the landmark site of the tissue T. Digital suture fixation system **50** is configured to provide the surgeon with dexterity that allows the surgeon to handle and place the support material S at the desired landmark on the tissue T prior to fixing the anchor **56** into the tissue.

The support material S includes materials suited to support the pelvic floor in repair of pelvic organ prolapse. Examples of suitable materials for support material S include synthetic materials, open mesh materials (woven or nonwoven), or biological (harvested tissue) materials. In one embodiment, support material S is provided as a woven polypropylene mesh material available from, for example, HerniaMesh, Chivasso, Italy.

FIG. 6C is a side view of the finger F employed to insert the anchor **56** through the support material S and into the tissue T. In one embodiment, the delivery device **54** provides a level of rigidity that enables the forceful deployment of anchor **56** through the support material S and into the tissue T. In some instances, the tissue T includes ligaments or other tough, durable connective tissue and the system **50** is compatible with the placement of anchors **56** into these and other tissues.

FIG. 6D is a side view of anchor **56** fixed into the tissue T to hold support material S in place at the desired landmark as identified by the surgeon.

FIG. 6E is a side view of another embodiment of a suture assembly including suture line **78** attached to anchor **56'**. In one embodiment, the support material S is loaded onto or otherwise coupled to a proximal end of the suture line **78** for subsequent delivery along the suture line **78** down to the placed anchor **56'**. For example, in one embodiment the anchor **56'** is placed in a sacrospinous ligament of the patient and a proximal end of the suture line **78** trails to a location outside of the patient. The surgeon attaches the support material S to the suture line **78** outside of the patient's body and is able to deliver the support material S intracorporeally to the identified landmark where the anchor **56'** has been placed. For example, in one approach the surgeon employs a pulley-like motion to move the support material S along the suture line **78** from a location outside of the patient intracorporeally to the anchor fixed in the desired landmark. Thereafter, the surgeon will tie off or otherwise secure the support material S to the tissue T. This approach allows the surgeon to accurately place the support material S intracorporeally at the landmark within the patient without actually visualizing the landmark.

Embodiments of the suturing system and devices described herein provide a method of digitally suturing tissue that is useful in many surgical procedures, including the treatment of pelvic organ prolapse. For example, embodiments provide a suturing system **50** suited for the surgical treatment of pelvic organ prolapse that is operable by a surgeon to suture a scaffold or other support to a ligament or other tissue to reinforce the pelvic floor. With some surgical procedures it is desirable to apply sutures to the sacrospinous ligament and/or in the arcus tendineus ligament to attach a synthetic scaffold thereto that is configured to support the pelvic floor and reduce or eliminate the undesirable effects of pelvic organ prolapse. The digital suture fixation systems described herein are compatible with these approaches to support the pelvic floor.

6

One embodiment provides a method of fixing a suture to tissue of a patient that includes placing an introducer onto a finger, attaching a suture assembly to the introducer, where the suture assembly has a suture line and an anchor attached to the suture line, delivering the introducer into the patient's body with the finger, and attaching the anchor to the tissue of the patient with the finger.

In a typical procedure related to the repair of pelvic organ prolapse, a catheter is placed in the patient's urethra U, along with other recommended, desirable, and preliminary steps in preparation for surgery. The patient is typically placed on an operating table in a lithotomy position (or modified lithotomy position) with buttocks extending just beyond an edge of the table. With the patient under anesthesia, a vaginal incision or a perineal incision or another suitable incision is made by the surgeon. Thereafter, the surgeon typically dissects tissue using his/her fingers (or a suitable instrument) and then palpates the patient with his/her fingers to identify a desired landmark, such as the sacrospinous ligament or arcus tendineus ligament or other tissue landmark.

The surgeon has thus gained intracorporeal access to the landmark with his/her fingers. The systems described herein allow the surgeon to place an introducer onto a finger and attach a suture assembly to the introducer for direct digital placement of the suture assembly to the landmark. To this end, the surgeon delivers the introducer and anchor into the patient's body with the finger, for example by following the intracorporeal path already dissected through the tissue. The systems thus allow the surgeon, with little additional effort, to attach the anchor to the tissue of the patient digitally with the finger/introducer. In one embodiment, the introducer is placed proximal a distal tip of the finger such that the distal tip of the finger is free to contact the intracorporeal tissue/landmark within the patient. The placement of anchors and/or suture line is repeated in this manner until the surgeon is satisfied with the repair of the pelvic floor.

In one embodiment, a suture line is attached to the deployed anchor and is available for delivering support material intracorporeally to the anchor previously placed in the patient. For example, the proximal end of the suture line is removed from the patient's body to a location where the surgeon may attach support tissue to the suture line. The support material may be accurately placed intracorporeally into the patient (e.g., by a "pulley" method of moving the support material along the suture line) since the distal end of the suture line is attached to the anchor that has already been placed/fixed in the desired landmark.

FIG. 7 is a side view of another embodiment of the digital suture fixation system **100**. In one embodiment, system **100** includes an introducer **102** that is attachable to a hand H and a finger F of the person, a delivery device **104** attached to the introducer **102**, and a suture assembly **106** that is removably attachable to the delivery device **104**. In one embodiment, the introducer **102** is provided as a glove that fits over the hand H and the suture assembly **106** includes a suture line **108** connected to an anchor **110**.

In one embodiment, the introducer **102** includes a flexible glove such as a nitrile glove or a latex-free glove and the delivery device **104** is provided as a rigid base attached to one of the fingers of the glove. In one embodiment, the glove **102** is fabricated from a polymer having a thin-walled section provided at least at the pad of the finger. As an example, the glove **102** is fabricated from a film having a wall thickness in the region of the pad of less than about 0.005 inches that is suited for providing digital dexterity to the finger.

In one embodiment, anchor **110** is a tissue penetrating anchor provided as a tube including a barb portion **111** opposite a base **120**.

FIG. 8A is a side view of delivery device **104** and FIG. 8B is a top view of suture assembly **106**. In one embodiment, delivery device **104** includes a post **112** extending from one of the fingers of the glove **102** and a flange **114** extending from the post **112**. In one embodiment, the anchor **110** includes a bore **122** formed in the base **120**, where the bore **122** includes a slot **124**. In one embodiment, the slot **124** is formed as a helical slot having an entry portion that opens to the base **120** and an end portion located at axial distance away from the base **120** inside of the anchor **110**.

The post **112** of the delivery device **104** is sized to fit inside of the bore **122**, and flange **114** is sized to mate with the slot **124**. Turning the anchor **110** by approximately 90 degrees (i.e., a quarter turn clockwise) secures the anchor **110** to the post **112** by seating the flange **114** in the slot **124**. In this manner, anchor **110** is removably secured to the delivery device **104**. After placement of the anchor **110** by the hand H inside of the introducer **102**, a delivery device **104** is detachable from anchor **110** by turning the delivery device **104** approximately 90 degrees counterclockwise relative to the anchor **110**.

In one embodiment, the delivery device **104** is a holder having a first mating surface configured to mate with a second mating surface formed on the base **120** of the anchor **110** such that the holder **104** is configured to decouple from the anchor **110** by separating the first mating surface from the second mating surface. Suitable mating surfaces between the holder **104** and the base **120** include adhesive surfaces, where at least one of the surfaces of the holder **104** and the base **120** is provided with an adhesive; mechanical surfaces such as tongue and groove surfaces as one example; or hook and loop surfaces where one of the surfaces of the holder **104** and the base **120** is provided with a loop structure that mates with a hook structure provided on the other of the holder **104** and the base **120**. In one embodiment, the first mating surface of the holder **104** is a convex surface and the second mating surface formed on the base **120** of the anchor **110** is a concave surface, or vice versa.

The suture line **108** is similar to the suture line **78** (FIG. 5). In one embodiment, suture assembly **106** is employed in a manner that is similar to suture assembly **56'** (FIG. 5) and provides a trailing suture line **108** that is configured to be directed from the anchor site out of the patient for access by the surgeon, which allows the surgeon to deliver support material S back along the suture line **108** to the landmark inside the patient. Thus, embodiments provide for the placement of support material into a small incision at a desired intracorporeal landmark where the surgeon does not have actual visualization of the landmark.

Embodiments of digital suture fixation systems have been described that include a digital introducer that is attachable to a finger that is used to guide an anchor delivery device intracorporeally to a patient. The introducer is configured to allow the finger to palpate and identify a landmark within a patient and the delivery device is configured to insert an anchor or a suture attached to an anchor into the landmark. Thus, the surgeon's finger is used to deliver the anchor/suture and the space formed in the dissected tissue to locate the landmark may consequently be reduced.

Although specific embodiments have been illustrated and described herein, it will be appreciated by those of ordinary skill in the art that a variety of alternate and/or equivalent implementations may be substituted for the specific embodiments shown and described without departing from the

scope of the present invention. This application is intended to cover any adaptations or variations of medical devices as discussed herein. Therefore, it is intended that this invention be limited only by the claims and the equivalents thereof.

What is claimed is:

1. A method of implanting a support in a patient, the method comprising:
  - forming an incision in the patient;
  - dissecting tissue layers away from the incision;
  - providing an anchor, and an anchor introducer that is wearable on a finger, where the anchor introducer includes a shelf and the anchor includes a tissue penetrating barb extending from a flange;
  - wearing the anchor introducer on the finger and positioning the anchor introducer such that at least a distal tip of the finger is available for palpating tissue internal to the patient;
  - attaching the anchor to the anchor introducer by sliding the flange of the anchor relative to the anchor introducer and engaging the flange of the anchor with the shelf of the anchor introducer;
  - inserting the finger that is wearing the anchor introducer into the incision and palpating a tissue landmark inside a pelvis of the patient with the distal tip of the finger;
  - driving the anchor into the tissue landmark inside the pelvis of the patient;
  - moving the finger that is wearing the anchor introducer and detaching the anchor from the anchor introducer;
  - associating the support with the anchor and securing the support to the tissue landmark inside the pelvis of the patient; and
  - removing the anchor introducer from the patient.
2. The method of claim 1, wherein the anchor introducer is a thimble sized for placement on a single finger, the thimble including a window through which a distal pad of the distal tip of the finger is exposed, the method further comprising:
  - palpating the tissue landmark inside the pelvis of the patient with the distal pad of the distal tip of the finger.
3. The method of claim 1, comprising pushing a tip of the anchor through the support and into the tissue landmark inside the pelvis of the patient thereby securing the support to the tissue landmark inside the pelvis of the patient with the anchor.
4. The method of claim 1, wherein the anchor includes a suture line connected to the anchor, the method further comprising:
  - pushing a tip of the anchor into the tissue landmark inside the pelvis of the patient; and
  - delivering the support along the suture line to the tissue landmark inside the pelvis of the patient; and
  - securing the support to the tissue landmark inside the pelvis of the patient with the suture line.
5. The method of claim 1, comprising pushing against the flange of the anchor and driving the tissue penetrating barb of the anchor into the tissue landmark of the patient.
6. The method of claim 1, comprising sliding the flange of the anchor away from the anchor introducer and disengaging the flange of the anchor from the shelf of the anchor introducer.
7. The method of claim 1, comprising palpating the tissue landmark inside the pelvis of the patient without visualizing the tissue landmark.
8. The method of claim 1, comprising associating the support with the anchor and securing the support to the

tissue landmark inside the pelvis of the patient without  
visualizing the tissue landmark.

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